APPENDIX A

MEDICAL HOMES NETWORK

Building Healthy Families

Definitions

The following definitions will used throughout this document:

- **Care Coordination Services Organization (CSO):** For the purposes of this document, the term CSO shall be used to describe the entity providing the infrastructure to the Medical Homes Network.

- **Beneficiary:** An individual who is Medicaid eligible and meets the criteria to enroll in the Medical Homes Network program.

- **Member:** An individual who is Medicaid eligible and has enrolled in the Medical Homes Network program.

- **Primary Care Physician (PCP):** An individual physician or group medical practice who agrees to serve as the Member's primary physician, contribute to the development and implementation of the care treatment plan, and participate in quality of care initiatives and reviews. At this time, the following practice specialties are considered Primary Care: Family Medicine, General Practitioners, Pediatricians, Internal Medicine, Federally Qualified Health Centers (FQHC), and Rural Health Clinics (RHC).

The Medical Homes Network (MHN) Program is a physician-driven service delivery system designed for Medicaid beneficiaries. Beneficiaries who choose to enroll in this program agree to utilize the primary care physician for their medical needs. This "partnership for care" enables the beneficiaries the comfort of knowing that they will receive coordinated medical services. Also, it is expected that beneficiaries enrolled in an MHN will utilize the emergency rooms less and have fewer hospitalizations due to enhanced primary care.

The goals of the Medical Homes Network program are to:

- Establish medical homes for Medicaid beneficiaries to promote continuity of care and improve care coordination for beneficiaries.
- Emphasize wellness and prevention to improve quality of life.
- Provide 24-hour access to a licensed healthcare provider.
- Provide more intensive care coordination to members as needed.
- Reduce improper utilization of the emergency room for non-urgent healthcare.
- Reduce pharmacy costs.
- Better utilize Medicaid resources through increased patient monitoring, evidence based resources, and physician accountability.
- Enhance beneficiaries' ability to participate more fully in health care decisions.

THE CONTRACT PROCESS

This section will provide the information necessary for preparing to initiate a Medical Homes Network (MHN) contract with the SCDHHS. SCDHHS will furnish potential contractors with a copy of the model contract upon request. The model contract has been approved by the Centers for Medicare and Medicaid Services (CMS). The terms of the contract are established and are not negotiable.

SCDHHS will enter into a contract with any qualified Network that meets the SCDHHS standards for Medical Homes Networks. Incentives will be based on a shared savings model. SCDHHS will share documented cost savings with the Network. An independent actuary under contract with the department has developed the formula for the distribution of savings. Savings will be calculated by a "look back" at claims experience. The independent actuary will establish the appropriate case-mix adjustments for population comparison. The savings must be defined by a reduction in the cost of care of enrolled plan members, versus the cost of care of comparable un-enrolled Medicaid beneficiaries. If the Network does not achieve savings, SCDHHS will impose a penalty on the Network and a portion, if not all, of the prospective care coordination fee payments must be refunded to the SCDHHS. SCDHHS will conduct periodic cost reconciliation. At a minimum, cost reconciliation shall be conducted semi-annually. The shared savings formula is attached.

The Network will receive a prospective payment. The expenses or costs of operating the Network are to be paid out of the generated cost savings. The prospective payment is a Per Member Per Month Care Coordination/Management fee that is based on the number of enrolled members. The payment is prospective in that it is an advance against the Network's anticipated savings. Thus the Network may be required to pay back a portion, if not all, of this advanced payment if the Network does not generate savings. This is the only payment that SCDHHS will make. Any PMPM paid to the participating physicians must come out of this payment, as must operating costs. The only limit SCDHHS will put on how the

Network spends the money will be the limitations/restrictions attached to Federal funds. The Network must submit its Physician PMPM formula and its shared savings formula to SCDHHS for approval. The Network will also be required to submit a cost report at the end of each contract year to account for how the money was spent.

SCDHHS will not contract with any individual and/or group of individuals having an outstanding debt with the agency. If any member of a group has an outstanding debt against SCDHHS, the entire group will be considered to have same.

The following Medicaid provider types may participate as a **Medical Homes-Primary Care Provider:**

- Family Medicine
- General Practitioners
- Pediatricians
- Internal Medicine
- Federally Qualified Health Centers (FQHC)
- Rural Health Clinics (RHC)

Other provider types wishing to participate in a Medical Homes Network should petition/contact the local entity. A listing of current networks may be obtained by calling 803-898-4614.

The potential contractor should send a letter requesting consideration for participation in the MHN program. The letter should include a statement of purpose, brief company background to include ownership, corporate status, major shareholders and/or company officers, location of network, basic Network structure, and the name of the primary contact. The letter should be addressed to:

Director, Division of Care Management
South Carolina Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

Upon receipt of this letter, SCDHHS will provide the applicant a copy of the MHN Application. This document details the entire application process. The applicant should develop/prepare a thorough written response to the application and should submit a total of six (6) copies (one original and five copies) of the response. This response becomes the potential contractor's official Application Packet and should be addressed to:

Team Leader, Department of Managed Care
South Carolina Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

MEDICAL HOMES NETWORK STANDARDS

Building Healthy Families

In order to ensure that services provided to Medicaid beneficiaries are of the highest quality, the following standards have been developed to guide the formation and development of Medical Homes Networks (MHN) within the South Carolina Medicaid program. For simplicity, SCDHHS will refer to the management entity associated with the Network as a Care Coordination Services Organization (CSO). These standards detail the requirements for (1) the Care Coordination Services Organizations, and (2) Information Technology Systems. Preliminary contract deliverables and sanctions are also included.

Attachment I
Enrollment Standards for Medical Homes Network Care Coordination Services Organizations

Attachment II
Information Technology Standards For Medical Home Networks

Attachment III
Deliverables and Sanctions

Attachment I

ENROLLMENT STANDARDS FOR MEDICAL HOMES NETWORK CARE COORDINATION SERVICE ORGANIZATIONS

SCDHHS will contract with a Care Coordination Service Organization (CSO) for the purpose of the development and maintenance of a Medical Homes Network. The Network shall be defined as the participating physician practices, any advisory boards, and the CSO. The CSO shall be the designated agent for the Network. Care Coordination Service Organizations (CSO) are to be experienced, responsive, responsible, and financially sound organizations that provide administrative support to the Network and the participating primary care practices. If the Network so chooses, it may disburse a Per Member Per Month (PMPM) Care Coordination fee for each enrolled member to each participating provider. The PMPM will be paid by the Network. The Network shall develop a formula for the distribution of the PMPM which shall be approved by SCDHHS. The State intends to share any documented cost savings with the network through the CSO by utilizing an agreed-upon formula established by independent actuaries contracted by the State. The CSO will be responsible for dividing the Network's share between the participating practices and the CSO, based upon the agreement established between the CSO and the practices. The CSO will be responsible for components and services as follows:

- Formal Care Coordination and Case Management;
- Service Utilization Management/Track services provided to members;
- Member Education;
- Disease Management;
- Provider Education and training on evidence-based medicine and Best Practice protocols;
- Pharmacy Management to include, but not limited to: Benefit Management Oversight, Prior Authorization and Clinical Risk Identification;
- Exception and performance tracking and reporting;
- Outcomes measurement and data feedback; and
- Distribution of any cost savings.

The Scope of Work the CSO is expected to perform consists of these components:

1. Development, maintenance and expansion of a network of physicians that will assume the responsibility of providing medical homes for Medicaid beneficiaries in their respective service areas. The CSO is expected to provide a sufficiently developed infrastructure to support the member practices in the management of the medical and health care needs of members to assure that all medically necessary services are made available in a timely manner. This infrastructure should include, at a minimum:
    - A protocol for care coordination/case management to include:

- Proposed care coordination staffing.
- Proposed methodology for defining which patients will receive care coordination services. Patients who are considered "high utilizers" and/or non-compliant must be targeted for care coordination.
- Proposed procedures to follow up with patients admitted to the hospital, seen at the emergency room, or by some other medical professional.
- Proposed procedures for addressing non-compliant members.

- Disease Management initiatives based on the network's demographics, including protocols for at least two (2) disease states.
- Pharmacy Oversight and Management.
- 24-hour call service/Help Line/Nurse Line that is staffed 24 hours per day, 7 days per week.

2. Assistance to the MHN to ensure their ability to provide:
   - Care Coordination and Case Management
   - Disease Management
   - Pharmacy oversight and management
3. Demonstrate budget neutrality or cost savings for services to beneficiaries in the plan.
4. Management of the medical and health care needs of members to assure that all medically necessary services are made available in a timely and cost efficient/effective manner.
5. Monitoring and follow-up on care provided by other medical service providers for diagnosis and treatment, to include externally referred services.
6. Ensurance that the participating PCPs meet the following standards:

   A. The practices must provide primary care and patient care coordination services to each member.
   B. The practices must provide or arrange for Primary Care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week.
   C. There must be prompt (within one hour) access to a qualified medical practitioner who is able to provide medical advice, consultation, and authorization for service when appropriate. PCPs must have at least one telephone line that is answered by office staff during regular office hours. (Use of an automated system to answer the phone is acceptable as long as patients are able to access a live person through one of the automated options.)
   D. PCPs must provide members with an after-hours telephone number. The after-hours number may be the PCP's home telephone number, an answering service, etc. The after-hours telephone number must be listed in the member's handbook. Changes to the after hours number should be reported to the Care Coordination Services Organization.
   E. The practices must provide preventive services as defined by the network advisory board.

F. The practices must offer general patient education services to all members and potential members as well as disease management services to members for whom the services are appropriate.
G. MHN PCPs must establish and maintain hospital admitting privileges or enter into an arrangement with another physician or group practice for the management of inpatient hospital admissions of MHN members.
H. The practices will assist the member by providing systematic, coordinated care and will be responsible for all referrals for additional medically necessary care to other health care providers.
I. The practices will be required to follow the recommended Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening schedules, as required by the Centers for Medicare and Medicaid Services (CMS).
J. The practices will be required to utilize the following standards for Appointment Availability:
    - Emergency care – immediately upon presentation or notification
    - Urgent care – within 48 hours of presentation or notification
    - Routine sick care – within 3 days of presentation or notification
    - Routine well care – within 45 days of presentation or notification (15 days if pregnant)
K. The practices will be required to utilize the following standards for office visit times:
    - Walk-ins – within two hours or schedule an appointment within the standards of appointment availability listed above
    - Scheduled appointment – within 45 minutes
    - Life-threatening emergency –must be managed immediately

The CSO must be an established entity with its own tax ID number. Organizations interested in participating in a MHN should call the SCDHHS Division of Care Management at 803-898-4614 to inquire about the contractual arrangements.
NOTE: A CSO that also operates a Medicaid Managed Care Organization (MCO) in South Carolina will not be allowed to conduct business as both a CSO and an MCO within the same county.

Minimum Criteria

A CSO/Network must meet the following criteria and be approved in order to be considered for participation in the Medical Homes Program. The identified protocols must also be submitted and approved by SCDHHS.

1. Must demonstrate experience as a Care Coordination Services Organization in a Medicaid managed care environment.
2. Demonstrated evidence of successful development of physician networks.
3. Demonstrated network and physician management to include:
    - Provider satisfaction data;
    - Cost effectiveness data; and

- Quality data (member satisfaction and documented Quality Improvement Program).

4. Appropriate credentials and Medicaid-specific experience of all staff personnel (either current to be documented in resumes or to be required and documented in job descriptions) dedicated to the program.
5. Demonstrated utilization management abilities to include:
   - Referral Management;
   - Drug utilization review; and
   - Practice guidelines.
6. Demonstrated ability to engage the target populations (PCPs and Beneficiaries/Members) resulting in provider and member satisfaction and to facilitate increased coordinated access to care.
7. Demonstrated ability to coordinate with and educate health care providers and to sustain participation and coordination with these providers. Submit documentation of education provided to the providers over the past 5 years. Submit evidence of provider retention over the past 5 years; provider retention must be at least 80%.
8. Demonstrated ability to identify and address quality of care issues (e.g., identify gaps between recommended prevention and treatment and actual care provided to members).
9. Demonstrated ability to apply nationally recognized, evidence-based clinical guidelines in the application of services.
10. Demonstrated ability to educate MHN members and/or their caregivers regarding child development, childhood diseases, and any particular health care condition and the needs brought about by health problems, with the goal of increasing MHN member and/or caregiver understanding and to enhance their effectiveness in self-care. Submit examples of education provided to the members over the past 5 years. Submit all materials used, description of activities, etc. conducted with members over the past 5 years. Include both English and Spanish versions.
11. Demonstrated ability to manage various health and any co-morbid conditions.
12. Demonstrated ability to assure ongoing monitoring and evaluation of MHN member health status. Submit detailed descriptions of activities implemented to address health status issues and the resulting effects in acute care costs.
13. Demonstrated ability to assure ongoing monitoring and evaluation of MHN provider service utilization and progress on program outcomes. Submit sample reports.
14. Demonstrated ability to manage and analyze MHN member and MHN provider demographic, utilization, and cost data. Submit sample reports.
15. Demonstrated ability to comply with current HIPAA regulations.
16. Demonstrated financial soundness. Each Network must provide assurances that the State of South Carolina, SCDHHS or Medicaid beneficiaries will not be liable for the Network's debt if the Network becomes insolvent. The Network must provide evidence of a reserve account with a

federally guaranteed financial institution. Additional Fiscal Requirements are found in the MHN Application.

17. Must provide management team's credentials and background summaries.
18. Demonstrated information technology proficiency to include
    - Enrollment tracking;
    - Re-determination tracking;
    - Data support for utilization management and case management services; and
    - Ownership of or a contractual relationship with a data warehouse or central database with the ability to provide monthly, yearly, and ADHOC reports to the advisory board, individual physicians, and SCDHHS.

    See Attachment II for more detailed specifications on IT/data system requirements.
19. Demonstrated care management protocols to include:
    - Staffing criteria;
    - Procedures for identifying patients in need of care management;
    - Ability to work with families and other community supports/providers,
    - Ability to engage members in care management;
    - Care manager access protocols (Please describe how a member accesses the care manager; i.e., assignment, request, chronic condition, missed appointment, etc.);
    - Care management protocols for specific diseases; and
    - Patient education methods and capacities.
    - *NOTE: The CSO may operate its 24-hour Help Line outside of South Carolina. However, in anticipation of care coordination services that must be delivered face-to-face, the CSO will be expected to employ or contract with local Care Coordinators.*
20. Demonstrated ability to begin full operation within 30 days of receiving a contract from SCDHHS.
21. None of the primary parties involved in the Network or any affiliated personnel can have any outstanding debt with SCDHHS.
22. In establishing/building its provider network, the CSO/Network must target medically underserved areas of South Carolina.
23. A CSO shall not be a subsidiary of a parent company currently engaged in a managed care contract with South Carolina Medicaid.
24. Protocols addressing the following:

    A. A protocol to ensure regular evening and weekend office hours to accommodate the needs of the members. This must be submitted within six (6) months of the Network beginning operations.
    B. A protocol to provide medical homes for Medicaid patients that do not have a medical home and/or use the Emergency Room as their PCP.
    C. A protocol to educate Medicaid beneficiaries on appropriate use of the ER and other medical services and to divert members from the emergency room to urgent care or primary care when appropriate.

D. A protocol to control, monitor and follow-up on care provided by other medical service providers for diagnosis and treatment.
E. A protocol for furnishing providers and members with evidence-based information and resources to support optimal health management.
F. A protocol that emphasizes and defines prevention and self-care
G. A data management, reporting and feedback process with Network members to track exceptions and performance, to improve health outcomes, document cost effectiveness, including monthly patient profile reports. SCDHHS will provide data to the Network and the providers, which detail the claims activities on all enrolled members.
H. A protocol on maintaining Medicaid eligibility, to include providing assistance to members in completing the eligibility renewal process to reduce the percent of members whose eligibility is interrupted due to failure to respond properly during the re-determination process.
I. A protocol to educate new and potential members on the enrollment process.
J. A protocol to ensure the cultural competency of the Network.
K. A protocol for involving the participating physicians in the oversight and direction of initiatives for the network to include:
    - ✓ Establishing best practices
    - ✓ Monitoring overall quality of care within the network
    - ✓ Monitoring overall network costs to Medicaid
    - ✓ Utilization of data management to improve healthcare for the state

In order to demonstrate the various skills and abilities detailed above, the interested CSO must answer a series of questions addressing the following:

1. Organizational experience;
2. Provider education and interface;
3. Beneficiary Help Lines which are staffed 24-hour per day/7 days per week and 24-hour/7 day access to the practice (This may be accomplished through an answering service. An answering machine that merely directs the members to the ER is not acceptable.);
4. Care Coordination system;
5. Care Coordination staff;
6. Provider engagement;
7. Disease Management system;
8. Quality Assessment and Improvement program;
9. Evaluation;
10. Shared savings distribution formula;
11. Care Coordination Per Member Per Month distribution formula;
12. References;
13. Data systems;
14. Protocols;
15. Previous External Quality Review experience; and
16. Enhanced care coordination to special populations.

Attachment II

INFORMATION TECHNOLOGY STANDARDS FOR MEDICAL HOME NETWORKS

1. General Characteristics

The MHN Information Technology (IT) System must be sufficiently sophisticated enough to support the many functions of the MHN program. It will contain highly confidential data whose handling is subject to various laws and regulations. The data sets will tend to be large. Although the ultimate responsibility for patient care remains with the physician or other provider, lost or inaccurate data can impede the ability of the MHN to support the provision of optimal care by the provider.

The MHN IT System must meet the following general characteristics:

- Compliance with Law and Regulations – The MHN's data system must comply with all applicable laws and regulations for the handling of confidential health information. This includes the requirements of HIPAA for Protected Health Information; HIPAA requires assurance of privacy and security, and mandates the use of certain formats for data transfers, among other requirements.
- Security – MHN IT systems must be secure from compromise by internal and external threats.
- Accuracy – The data system must maintain data accurately and without corruption.
- Stability and Reliability – The data system must be stable, not subject to sudden failures or unreliable behavior.
- Robustness – The data system must have the capacity to handle very large data sets without suffering from undue degradation of performance.
- Redundancy – At a minimum, the data sets must be backed up on a scheduled basis, and the backup copies stored on separate media in a separate geographic location from the main data center.

2. Systems

The optimal system will provide access to data via secure direct client access and secure web-based access to the data. The system must be able to import, store, process, and export large volumes of data in an acceptable amount of time. Response times for online query will be sub-second. Interface speeds will be in accordance with current industry standards. The system's architecture must be kept current with industry standards.

Please note that all interface layouts and EDI communications protocols will be dictated by SCDHHS. All EDI communications must be encrypted to meet or exceed HIPAA standards.

In general, MHN programs will require two different types of systems: **Transaction Systems**, which manage the day-to-day operations of the MHN program with real-time interaction; and **Reporting and Analysis Systems**, which provide the reports for monitoring and analyzing the performance of the program, recognizing trends, and identifying problems and opportunities.

A. Transaction Systems

Transaction systems allow quick access to needed data for support of daily tasks. MHNs require the following Transaction Systems:

1. Enrollment System

   The MHN must be able to accurately track which beneficiaries are enrolled in the program at any given time. The Enrollment System must support storage and retrieval of at least the following information for each Member:

   a. Name
   b. Medicaid ID #
   c. Address
   d. Date Of Birth
   e. Primary Physician
   f. Enrollment Status (Enrolled, Disenrolled, etc.)
   g. Date of Enrollment
   h Date of Disenrollment

2. Medical Management System

   The Medical Management System must support, at a minimum, the following functions:

   a. Referral Management

      The Primary Care Case Management (PCCM) model embodied in the MHN program requires that members receive a referral from their primary physician for non-emergent care from other providers. Therefore, the MHN must have an information system that can record, track, and verify referrals in a real time manner. The system must also support the functions of preauthorization and post-authorization in a similar way.

The Referral System must record, at a minimum:

- ✓ Name of the member being referred
- ✓ Member's Medicaid ID
- ✓ Identity of the referring doctor
- ✓ Identity of the provider being referred to
- ✓ Condition or diagnosis of the patient for which referral is sought
- ✓ Service being requested
- ✓ Time limit or number of visits authorized
- ✓ Referral or authorization identifying number

The Referral System must have functionality that immediately identifies attempted referrals that are duplicates of existing still-valid referrals, or that violate medical policy in some way (referrals to providers who are not Medicaid providers, for example).

b. Care Management

Once high-risk, high-utilizing, or vulnerable patients are identified, the MHN program is responsible for monitoring the care of such patients. For this, a system is required that supports ongoing care management by clinical personnel.

The Care Management System must include at least the following functions:

1. Intake – the ability to enroll a new patient into the Care Management process. Information collected here must include patient demographics, diagnoses and conditions, treating physicians, medications, a current problem list, and contact information for all relevant providers and family.

2. Contact Recording – the ability to record the relevant information regarding each contact with the patient, their providers, or others relevant to the case. Contact recording must be made simple and fast, so that it can proceed in real time, during a telephone call, for example. Retrieval of records from prior contacts must be simple, fast, and intuitive.

3. Reminders – the ability to prompt the care manager with a pre-recorded reminder to perform a task (such as, call the patient) at some previously decided interval (such as, one week from the last contact).

4. Best Practice Protocols – the ability to call up relevant clinical protocols representing best practices for the management of both common and complex diseases.

c. Drug Utilization Management

The MHN program must support optimal regimens of medications for members. Some mechanism must be provided for educating physicians as to the most clinically effective and cost effective drugs for each condition. At a minimum, the MHN program must provide online access for physicians to the drug education information it has developed.

d. Quality Management

The MHN program must assure and improve the quality of care while it is working to reduce unnecessary costs. The information system must support quality management functions by:

1. Tracking industry-standard quality measures, such as HEDIS;
2. Tracking complaints by providers and members, with recording of the process of investigating the complaint, as well as recording the result of the investigation and any corrective actions taken; and
3. Tracking member satisfaction and provider satisfaction measures.

e. Patient Education

The MHN program supports healthy behaviors by members and helps educate them on relevant aspects of their medical conditions, medications, planned tests or procedures. At a minimum, the MHN information system makes effective patient education materials available online for physicians and/or patients.

3. Provider Service System

The MHN program requires the recruitment and education of providers, and collaboration with and among them. The Provider Service System must include the following functions, at a minimum:

a. Contact Management – storage and retrieval of provider contact information, plus tracking of all contacts with a provider in the

course of recruitment, contracting, inservice training, education, and problem resolution.

b. Practice Management Information – storage and retrieval of locations, office hours, age restrictions, etc.

c. Contract Information - storage and retrieval of information on the provider's contracts with SCDHHS and with any MHN Care Coordination organization.

d. Credentialing Information - storage and retrieval of information on provider's medical specialty, licensure, malpractice insurance, etc.

4. Financial System

The MHN program will potentially handle significant sums of Medicaid funds, in administrative fees and shared savings payments, and must possess adequate financial systems for the purposes of accounting, payments, audit and control. In addition, the MHN program may pay out performance bonuses to providers, and must have sufficiently powerful and flexible financial systems to calculate, pay, and account for such bonuses. SCDHHS anticipates that the MHN program will become the claims processor for the physicians in the network: receiving claims (electronically and via hard copy), processing claims, and paying claims. The financial system must be able to expand to easily accommodate this function without causing any disruption to the participating providers.

The MHN Financial System must, at a minimum, include the following functions:

- Accounting
- Accounts Payable
- Accounts Receivable
- Provider accounting for calculation and payment of performance bonuses

B. Reporting and Analysis Systems

MHNs must be able to produce a wide range of reports for both internal and external use, and be able to perform sophisticated analyses on very large sets of claims and enrollment data in order to optimally support the provision of quality, cost-effective care by contracted providers. A Reporting and Analysis System will perform these functions.

The MHN Reporting and Analysis System will have the following design:

1. The Data Warehouse uses an industrial-strength relational database, typically based on Structured Query Language (SQL).

2. The Data Warehouse has strong capabilities for data import and data export. It will likely be receiving data from multiple distinct sources, and must be able to output data into a variety of industry standard formats, to enable end-user presentation and manipulation in industry standard office productivity applications such as spreadsheets and PC databases.

3. The Data Warehouse contains all of the relevant data needed for the MHN's reporting and analysis function, receiving data feeds from, at a minimum, Enrollment, Claims, Medical Management, and Financial Systems data. Data in the Data Warehouse should include, at a minimum:

    a. Member demographics
    b. Claims information, including at least:
        1. Date of Service
        2. Service/Medication Provided
        3. Quantity of Service/Medication
        4. Provider of Service
        5. Place of Service
        6. Diagnosis
        7. Payment
        8. Referring/Prescribing Provider
        9. Referral/Authorization Code
        10. Date Paid
        11. Claim Identification Number
        12. Enrollment/Disenrollment Dates
        13. Primary Care Provider
    c. Primary Care Provider information
    d. Information on other providers
    e. Referral/Authorization data
    f. Case Management data
    g. Drug Utilization Data
    h. Quality Management data
    i. Financial data, including information on performance bonuses paid

The MHN Reporting and Analysis System will include strong tools for both report-generation and analysis of patterns and trends. The Reporting function must include, at a minimum:

1. A comprehensive set of standard reports, including, at a minimum:

    a. Enrollment reports, including monthly reports on currently enrolled, newly enrolled, and disenrolled beneficiaries.

    b. Referral/authorization reports, including monthly reports on members' referred/authorized for services.

    c. Utilization reports, including monthly reports on hospital usage, Emergency Room usage, and medication usage.

    d. Case management reports, including monthly reports on members with target diagnoses, members in case management, and utilization by target disease.

    e. Quality management reports, including tracking of industry-standard measures such as HEDIS, plus member satisfaction and provider satisfaction.

    f. Health maintenance reports, including quarterly reports on members who have not had recommended health maintenance interventions (such as Child Health Checkup, or Diabetic Eye Exam) within prescribed or recommended time frames.

    g. Provider profiling, report card, and performance bonus reports.

    Reports must have the ability to be run on a "to be determined", schedule.

2. In addition to a comprehensive set of standard reports, the data system should include strong tools for generating ad hoc reports as the need arises, including, at a minimum:

    a. A user interface sufficiently straightforward that it is usable by non-technical end users;

    b. Ability to output results as tables and/or graphs of various types, as chosen by the user;

    c. Ability for the user to make comparisons, sort lists, drill down, roll up/combine, and identify results that exceed or fall below some threshold; and

d. Ability to import and export data in various common formats for use in common office productivity tools such as spreadsheets and PC databases.

Attachment III

DELIVERABLES AND SANCTIONS

The Network shall, at a minimum, submit the following to SCDHHS:

- Definition of the preventive services to be offered by each participating practice, no later than six (6) months after commencing operations or the execution/renewal of the contract.
- A monthly log of all after-hours calls from members to the practice and to the Help Line and the disposition of those calls.
- An electronic monthly listing of PCPs participating in the Network.
- On a monthly basis, the MHN's Grievance and Appeal Logs with Summary Information.
- A report of the participating PCPs' level of compliance with the practice requirements to be submitted every six (6) months.
- The disease states which the Network intends to target, including the interventions to be used and the anticipated outcomes no later than six (6) months after commencing operations.
- Documented contact with each new member within three (3) months of enrollment.
- The identified quality of care issues within the Network's area and a Plan of Action to address these issues within six (6) months after commencing operations or the execution/renewal of the contract.

The State shall employ a variety of sanctions including, but not limited to, the following:

- Withholding of Network PMPM;
- Monetary penalties;
- Suspension of enrollment privileges;
- Suspension of marketing activities; and
- Termination of Contract.